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A 078	482.13(f)(3)(i) SECLUSION & RESTRAINT FOR BEHAVIOR The use of restraint or seclusion must be selected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on medical record review, policy and procedure review, hospital document review and patient and staff interviews, hospital staff failed to utilize less restrictive interventions, specific to the patient's care needs, which led to the use of manual and psychiatric restraints (4 point restraints) for 1 of 1 sampled patients (patient #1). Specifically, the hospital failed to ensure a policy and procedure was in place for staff to follow in the event a patient refused the search and body check upon admission. Findings include: Medical record review conducted on 8/4/05 revealed patient #1, a 26-year-old male, was admitted on 7/24/05 with the diagnoses of Major Depression and Adjustment Disorder. The admission nursing note, dated 7/24/05 at 1830 (6:30 PM) revealed, "...Per physician, patient was in prison and was raped in the past. Patient was in treatment room with CNA (Certified Nursing Assistant) and patient refused to comply with skin check of admission process. CNA notified RN that patient was being noncompliant. Mediation team contacted for assistance with patient check-in. Upon arrival of mediation team members, patient began backing down hall and swinging at staff." According to the "Interdisciplinary Progress Note for Manual Restraint/ITO/Psychiatric Restraint" located in the	A 078		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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medical record, patient #1 was placed in manual restraints at 1846 (6:46 PM), then psychiatric restraints at 1850 (6:50 PM). He was released from restraint at 1910 (7:10 PM) on 7/24/05.

Medical record review revealed patient #1 was assessed by a physician assistant (PA) while patient #1 was in restraints. In a progress note dated 7/24/05 at 1930 (7:30 PM) the PA documented "asked to evaluate 26 year old male who sustain several injuries when he was physically restrained - Patient remains in 4 point restraints. Patient angry and tearful - Has tender raised hematoma to left mid forehead quarter sized - tender quarter raise hematoma to right forehead at hairline. Severe tender areas about scalp. c/o (complains of) feeling dizzy. Has 1/8" laceration lateral right brow - cleansed and closed with steri strip. Has subconjunctival hemorrhage to medial lower eyelid. c/o pain with palpation of several teeth. c/o difficulty swallowing. ... Multiple small abrasions about arms and upper body. ... Refer to Grace ER to consider for CT of head and neck."

Further review of the medical record revealed patient #1 was assessed by an attending physician. The attending physician documented "Patient grossly agitated and violent with staff at check-in. Forcibly restrained with visible injury to face and head. Patient upset at request to drop pants at check-in. Patient has history sexual assault in prison. Now upset but not agitated. PA has dressed wounds. CT of head ordered. No evidence of contraband by my observation. My order to forgo further search to prevent additional altercations."

Medical record review revealed patient #1 was

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reassessed on 7/25/05 by a physician assistant (PA). The PA documented, "I was called to evaluate this patient who was complaining of pain. ... Stable and not in any kind of distress. Patient has an order for neurology, ophthalmology and medical consult."

Review of the physician's orders revealed patient #1 was ordered to have an ophthalmology consult, a medical consult, a neurology evaluation, a head CT scan without contrast, x-ray of the left hand and C - spine x-ray on 7/25/05. On 7/26/05 a dental consult was ordered.

Medical record review revealed the results of the ophthalmology consult on 7/26/05. The physician wrote, "patient reassured, expect full recovery."

Medical record review revealed the results of the medical consult on 7/25/05. The physician recommended the following: "He will need a dental opinion for his broken tooth and for the tongue laceration. X-ray of the left hand to exclude any fractures of the fingers. He needs some Motrin for pain on a as needed basis. An eye consult to exclude any intra-ocular bleed and hemorrhage. .... He may benefit from a neuro consult."

Medical record review revealed the results of the neurology evaluation on 7/26/05. The physician wrote, "Neuro status is now back to normal."

Medical record review revealed the results of the head CT scan without contrast on 7/26/05. The physician wrote, "No acute intracranial process. Bilateral ethmoid opacities suggesting sinusitis. There is a clinical history of blurred vision in the

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right eye. CT of the orbits/facial bones without and with contrast would be helpful in excluding an acute process as the etiology for blurred vision."

Medical record review revealed the results of the cervical spine series on 7/25/05. The physician wrote, "Mid/upper cervical curve reversal suggesting muscle spasm, No acute fractures or subluxations, Ligamentous/soft tissue calcification adjacent to the 1st rib."

Medical record review revealed the results of the left hand series on 7/25/05. The physician wrote, "Tiny non displaced avulsion fracture of the volar aspect base of the left 2nd middle phalangeal base."

Review of patient #1's medical record revealed a CNA Checklist, which staff referred to as the "littleman sheet". The CNA Checklist was divided into four sections: I Physical Status, II Orientation to Unit/Ward, III Patient Search and IV Care Provided. On the sheet is a drawing of the posterior and anterior of a body which is used for the CNA to indicate any bruises, scars, tattoos, etc. on the patients body. The CNA Checklist is initiated and completed by the CNA on admission to the unit.

On 8/4/05 the hospital policies and procedures entitled "Search and Seizure" and "Admission of Patient and Hospital Orientation" were reviewed. The "Admission of Patient and Hospital Orientation" policy stated "Duties and documentation delegated to CNAs, (c) Have patient undress and check patient's body for: Pedunculi, rashes, birthmarks, operative scars, vaccinations, bruises, scratches, moles, cysts, edema, deformities, enlarged abdomen, noting

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personal hygiene, color of hair and eyes and list on the CNA Checklist." There was no evidence in the "Admission of Patient and Hospital Orientation" or the "Search and Seizure" policy regarding guidelines staff should follow if the patient refused the admission search and skin check.

On 8/4/05, the hospital document entitled "Investigation Report Summary", dated 7/26/05, was reviewed. The document was prepared by a hospital patient advocate. The patient advocate concluded "Patient Advocacy Services completed their investigation and were unable to substantiate allegations of physical abuse." In the report, the advocate indicated she interviewed patient #1's admitting physician on 7/26/05 and "He stated that the patient expressed that he was worried about being behind locked doors again and that he had been raped in prison. The physician stated that he had dictated a note that restrictive interventions were contraindicated with the patient but the staff would not have had access to that information at the time of the intervention."

On 8/4/05, a hospital police department document entitled "Supplementary Investigation" dated 8/2/05 was reviewed. The document revealed "there is insufficient evidence to continue this incident as a criminal investigation....I have interviewed the mediation team that responded to the incident and haven't found any actions that would constitute abuse or an assault. There is no further evidence in this matter and it is considered closed."

An interview was conducted with the patient advocate on 8/4/05. The advocate reported "I

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take it very seriously", referring to "a head injury occurring after a restraint". The advocate also reported "It appeared it was a very intense struggle" and she notified the police chief (hospital) "immediately."

In interview with patient #1's admitting physician on 8/5/05 revealed, the patient was "mouthy" in the emergency room at the medical hospital but was "not physically aggressive." When he arrived at the psychiatric hospital he was "not aggressive and contracted for safety." He signed into the hospital voluntarily. The patient "did complain of being anxious" related to being behind closed doors and his history of being in prison. The physician discussed the patient's history of sexual assault with patient #1. The physician felt patient #1 would have a "short admission" and then be linked to out-patient treatment. The physician stated the patient was "perfectly compliant with me" and no special precautions were ordered upon admission. The physician reported he was paged about 15 minutes after patient #1 was admitted to the unit. The physician stated "By the time I got upstairs he was in restraints...". The physician further revealed he stayed with patient #1 until he was released from restraints and the physician ordered the rest of the search to be "waived." The physician described the incident as "rare but unacceptable."

On 8/4/05 and 8/5/04 interviews were conducted with staff involved in the restraint episode of patient #1 on 7/24/05. Interview with staff #2, a Registered Nurse on duty on 7/24/05, revealed she completed the RN assessment of patient #1 and staff #11 (a CNA) took patient #1 to the treatment room to complete the CNA Checklist. Staff #2 stated that Staff #11 had asked patient

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#1 to disrobe and patient #1 took off his shirt. Patient #1 became agitated when asked to take off his pants for the body check (to check for scars, tattoos, etc.) Staff #11 called and asked staff #2 for help completing the sheet (CNA Checklist). Patient #1 went into the hall where there were three to four other staff members present. Patient #1 announced he was a 'Golden Glove' and he was going to "knock everyone out." The mediation team arrived and patient #1 began "kicking and swinging at staff." Staff #2 reported staff members told patient #1 to "comply" and "we have to do the 'littleman sheet' (CNA Checklist)." Staff #2 further revealed "it's policy" (to complete the CNA Checklist) and she reported "people have been put in restraints to complete the 'littleman sheet'."

Interview with staff #3 (a CNA) on 8/4/05 revealed, she was part of the mediation team called to assist with patient #1 on 7/24/05. She stated patient #1 was "on the hall bouncing up and down with hands clenched all because of the 'littleman sheet'." Staff #3 revealed "The more people who got there, the worse he got." Staff #3 stated,"(We) have to do 'little man sheet,' it's not optional." Additionally, staff #3 reported "I've never seen a patient fight like that since I've been here."

Interview with staff #6 (a CNA) revealed he worked on ward 104-L (where patient #1 was restrained). Staff #6 stated when he arrived on unit from his "supper break", patient #1 was "standing with his shirt off in a boxer stance" and patient #1 was yelling "he had been raped in jail." Staff member #6 further stated, the "'little man sheet' is something we have to do-it's policy. We've held many women down that don't want to

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take their pants off." Staff #6 reported that patients are sometimes put in restraints in order to complete the "little man sheet"." Staff #6 also revealed two patients have had to be restrained in the last month to do the "little man sheet." "We always do a 'little man sheet' - I've never not done one."

On 8/5/05, the hospital document entitled "Serious Incident Analysis" was reviewed. This document was prepared by the Division Director of Division A (where patient #1 was located) in response to patient #1's restraint on 7/24/05. The document stated, "There were two significant factors that contributed to this event (patient #1's restraint). 1. After the patient arrived on the ward, there was no mechanism in place for ongoing communication with the admitting psychiatrist re: this patient. 2. There is currently no guideline in place for nursing staff to follow in the event a patient is refusing to participate in the initial search (i.e. calling the psychiatrist, delaying the search, etc.)." Additionally the Division Director recommended that the current search and seizure policy be evaluated to determine if there can be guidelines/procedures incorporated for nursing staff to follow in the event a patient is refusing to comply with the initial search.

On 8/5/05 an interview was conducted with the Division Director. She reported that she does an analysis after serious occurrences to determine "what went right and what went wrong." She stated that "it is the exception rather than the rule that someone has to be restrained to be searched." The Division Director noted after the incident involving patient #1 that there was "nothing in place as to what steps are to be followed if a patient refuses to be searched." She

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also stated, "the rigidity of the search has come about because of safety issues (related to patients bringing in contraband to the hospital)."

On 8/4/05 an interview was conducted with the Chief of Standards/Compliance. She reported that the hospital was in the process of changing the hospitals policy on Search and Seizure. With the new policy, she indicated guidelines will be in place for staff to follow in the event the patient refuses the search and body check i.e. "if the patient objects, staff can stop the search based on a physician's order."

On 8/4/05 an interview was conducted with patient #1. Patient #1 reported that staff #11 (a CNA completing the CNA Checklist for patient #1) "asked me to undress to fill out the 'littleman sheet'." Patient #1 further reported that he took off his shirt and he "had no problem with that." Patient #1 reported, staff #11 "asked me to undress completely" and patient #1 stated "I feel uncomfortable - I'd like to have a witness." Patient #1 added, he requested to see his doctor. Patient #1 reported he "had problems in prison (history of sexual assault in prison)." Patient #1 stated "I will not undress for you." Patient #1 then stepped into the hallway and "staff circled me and I felt threatened." Patient #1 stated, "I went into defense mode and they (staff) said 'we're going to take your pants off'." Patient #1 reported "I don't deny swinging at the guy to the right of me and kicking at another guy." Patient #1 continued, "I had a knee in my back and my head beat into the floor." Patient #1 stated he "had a chipped tooth" and was "spitting up blood" after the incident."

There was no evidence revealed in interview or in

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A 078	Continued From page 9 the patient's medical record that hospital staff explored less restrictive interventions to facilitate the completion of the CNA checklist. No attempts were made by staff to delay the search, contact the physician, or obtain a witness for the search per the patient's request.	A 078		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on policy and procedure review, medical record review, and staff interview, the RN failed to supervise and evaluate the care of the patient for 1 of 1 sampled patient (patient # 1) on the psychiatric unit 104L. Specifically, nursing staff was not present with the CNA during the patient search and skin check as outlined in the hospital's policy and procedure. Findings Include: The hospital policy and procedure entitled "Admission of Patient and Hospital Orientation" was reviewed on 8/4/05. The policy stated, "A. Duties and documentation delegated to CNA's 3. Take the patient to the treatment room and explain examination procedure to patient. The RN is present at this time and remains present throughout the examination. (a) Search patient. (b) obtain weight, height, TPR, and B/P and chart on CNA Checklist (Form # DMH 2-24-04). (c) Have patient undress and check patient's body for.... (d) Allow the patient to redress. Provide clothing if needed." The policy also stated, "B. Duties and Documentation by RN, 4 - Recheck	A 204		

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and sign the CNA data collection on CNA Checklist. (Reminder: RN is present during search and examination of the patient."

Review of hospital policy and procedure entitled "Search and Seizure"on 8/4/05 revealed, "IV. - Searches Require Two Or More Staff Members to Conduct. IV A. - During any search, there are two or more staff members present, one of which is the same sex as the patient."

Medical record review conducted on 8/4/05 revealed patient #1, a 26 year old male admitted on 7/24/05 with the diagnosis of Major Depression and Adjustment Disorder. The admission note, written by the admitting RN (staff #2) on 7/24/05 at 1830 (6:30 PM) revealed, the "patient was in treatment room with CNA (staff #11) and patient refused to comply with skin check of admission process. CNA notified RN that patient was being noncompliant. Mediation team contacted for assistance with patient check-in."
There was no evidence in the medical record that a RN was present while staff #11 conducted the search and skin check of patient #1 as specified in the hospital's policy and procedure.

Further medical record review revealed on 7/24/05 at 2045 the staff #2 wrote, "(Patient) in treatment room with CNA for rest of check-in. Patient became resistive with CNA when asked to remove pants for skin check. CNA called office and notified this writer that patient was refusing mandatory skin check. Mediation Team called for assistance."

Interview with patient #1 on 8/4/05 revealed, during patient #1's admission assessment, he

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A 204	Continued From page 11 was uncomfortable during the search and requested a witness to be present. Patient #1 confirmed only one staff member was present during the search and skin check. Telephone interview with staff #11 (a CNA), who admitted patient on 7/24/05 was conducted on 8/5/05. It was confirmed staff #11 was alone with patient #1 while attempting to conduct the search and skin check. Staff #11 further reported he was conducting the search alone, "as usual, except when there is a problem." Interview with administrative staff on 8/5/05 confirmed the RN was not present during the search and skin check of patient #1 as outlined in the hospital policy and procedure. Administrative staff provided a newletter that will be circulated in August 2005 that stated "Reminder - EVERY time section one (1) of the CNA Checklist (aka "Littleman Sheet") is completed, The RN must be present to observe and assess the patient."	A 204		